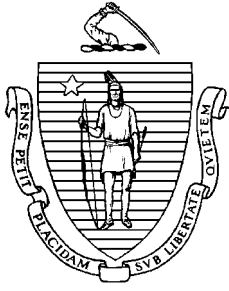


**The Commonwealth of Massachusetts
Department of Public Health
Division of Health Professions Licensure
Board of Registration of Nursing Home
Administrators
239 Causeway Street
Boston, MA 02114
www.mass.gov/dph/boards
617-727- 4499**

INSTRUCTIONS FOR LICENSING APPLICATION

General Information: Applicants for Nursing Home Administrator licensure **MUST** have completed a Board approved Administrator in Training internship to be eligible to submit a licensure application and take the national examination.

1. All application materials, including forms that are filled out by other individuals, must be submitted at the same time in a large envelope.
2. Provide a self-addressed envelope to your endorsers with your Reference Forms, Physician Form, Administrator Certificate of Internship Training [completed after final Board approval of AIT program]. After the individual has completed the form, he/she must seal it in the return envelope you provide, sign his/her name across the envelope seal and return it to you.
3. Once the application packet is submitted, the Board will provide you with information regarding contacting Professional Examination Services to schedule a test date. For more information, please go to the National Association of Boards of Examination of Long Term Care Administrators' [NAB] *Information for Candidates, Nursing Home Administrators* handbook available at www.nabweb.org.
4. Retain a copy of the complete application package for your records.

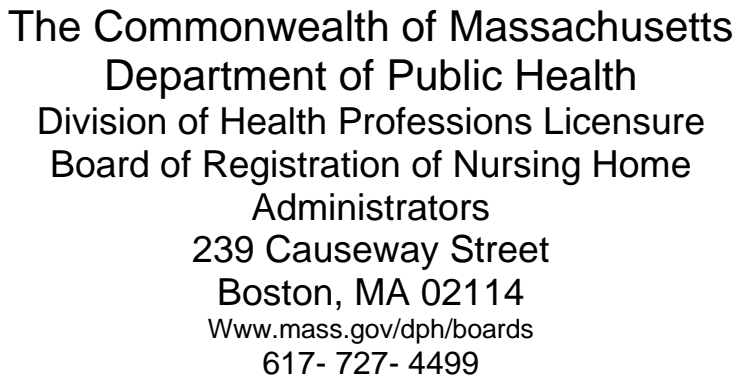


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Nursing Home Administrator License
APPLICATION PACKET CHECKLIST

The following must be included for a complete application. Please complete and enclose this checklist with your application. Incomplete applications will be RETURNED to you.

- _____ Application Form
 - _____ Reference List
 - _____ Photograph [2"x2", passport style]
- _____ Fee: \$51.00, payable by check or money order to the Commonwealth of Massachusetts NH
- _____ Four Reference Completed Reference Forms in signed, sealed envelopes:
 - _____ 3 professional
 - _____ 1 personal
- _____ Physician Form
- _____ Administrator Affidavit Certificate of Internship Training [in a signed, sealed envelope]



Applicant Name: _____

Last	First	Middle

No.	Street	Apt. #
City/Town	State	Zip Code

No.	Street	Apt. #
City/Town	State	Zip Code

Social Security Number (Mandatory): |_|_|_|-|_|_|-|_|_|_|_|_

Date of Birth: / / /
 MM DD YYYY

Place of Birth: _____

Have you previously filed an application (Yes)____ (No)____

ALL QUESTIONS MUST BE ANSWERED

1. List any licenses/certifications you hold in the United States or any country or foreign jurisdiction and the state/jurisdiction from which the license/certification was originally issued. Please attach a certificate of standing from each state or jurisdiction in which you are licensed/certified, indicating the status of your license.

2. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary):

3. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary):

4. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary):

5. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary):

6. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than \$100.00 was assessed? Attach a separate sheet explaining. Yes: ☐ No: ☐

REFERENCES

List the names of the three professional people whom you have asked to file a reference form with this application. **(NOT RELATIVES OR SUBORDINATES)**

1. Name _____
Title or position _____
2. Name _____
Title or position _____
3. Name _____
Title or position _____

Provide the name of the personal character reference who is providing a personal reference form with this application.

4. Name _____
Years Known _____

The following is signed under penalty of perjury: The undersigned hereby applies for a certificate of registration under terms of MG.L. c-112, s.s. 108-117, and vouches for the truth and accuracy of all statements and answers herein contained, with full knowledge of the fact that FRAUD OR MISREPRESENTATION IS GROUNDS FOR REFUSAL, OR SUBSEQUENT REVOCATION OF REGISTRATION.

I further attest that, pursuant to MG.L. c. 62C, s. 49A, to the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law.

**Please attach recent
2"x 2" Photograph here**

Signature of applicant

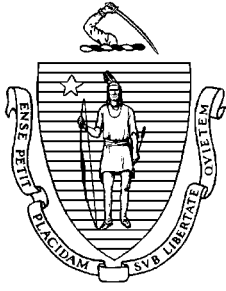
Date

Notary Name (print)

Notary Signature

My commission expires: _____

[Seal]



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REFERENCE FORM

You have been requested to provide reference information for _____, an applicant for registration as a Nursing Home Administrator in Massachusetts under the provisions of Section 74, Chapter 13 of the General Laws of this Commonwealth. Pertinent information concerning the applicant will be helpful to the Massachusetts Board of Registration of Nursing Home Administrators.

In order that the provisions of the licensing law may be effective in safeguarding public health, safety and welfare, the Board of Registration of Nursing Home Administrators has been charged with the responsibility of limiting the use of the title "Nursing Home Administrator" only to those who are found qualified and suitable for that profession. As one of the applicant's references, you are familiar with his/her professional work or have knowledge of his/her ability, character and reputation. The Board would appreciate information which bears upon the extent of the responsibility borne by the applicant in his/her professional work as well as your opinion of his/her professional competence and character.

The Board appreciates your cooperation in supplying the information requested on the enclosed sheet. Once you have completed the form, please place it in the envelope provided and sign your name across the envelope seal. Then return it to the applicant.

MASSACHUSETTS BOARD OF REGISTRATION OF NURSING HOME ADMINISTRATORS

REFERENCE FORM

Please type or print clearly:

1. NAME OF APPLICANT _____

2. PROFESSIONAL, OR OTHER RELATIONSHIP TO APPLICANT

3. NUMBER OF YEARS YOU HAVE KNOWN APPLICANT _____

4. PLEASE EVALUATE THE APPLICANT IN THE CATEGORIES OF WHICH YOU HAVE
PERSONAL KNOWLEDGE:

a. Professional knowledge and experience:

b. Character with respect to honesty, integrity, and general conduct:

5. DO YOU RECOMMEND THE APPLICANT FOR REGISTRATION AS A NURSING HOME
ADMINISTRATOR: YES _____ NO _____ If no, please attach a detailed written
explanation of your reasons for not recommending this applicant.

6. OTHER COMMENTS:

(Attach an additional sheet of paper, if you wish to make additional comments)

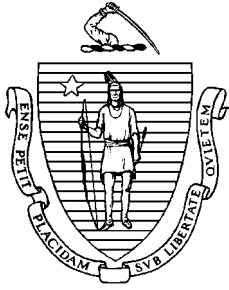
I hereby certify that the information given above is correct to the best of my knowledge and
belief, and opinions expressed above represent my best judgment. I hereby agree to provide
further information to the Board if requested to do so.

Name (type or print clearly) Signature

Business Address Date

City and State Zip Code Occupation

Home Address City, State Zip Code



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PHYSICIAN FORM

1. NAME OF APPLICANT: _____
2. NAME OF LICENSED PHYSICIAN: _____
3. ADDRESS OF PHYSICIAN: _____
No. Street Apt. #

City/Town State Zip Code
4. PHYSICIAN STATE LICENSE NUMBER: _____
Number Expiration Date

I hereby certify that the above named applicant is in good health and has no mental or physical impairment that would prevent him or her from discharging the responsibilities of a Nursing Home Administrator.

Physician Signature

Once you have completed this form, please place it in the envelope provided and sign your name across the envelope seal. Then return it to the applicant.



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ADMINISTRATOR AFFIDAVIT CERTIFICATE OF INTERNSHIP TRAINING

_____, _____,
(Trainee Name) (Degree Level)

I, _____, _____, hereby certify that
(Administrator) (License number)

the trainee named above has trained in the _____
(Name of Nursing Home)

_____, from _____ to _____, working ____
(mm/dd/yyyy) (mm/dd/yyyy)

_____ hours per week, for a total of _____ hours.

During this training period, the trainee named above, has worked exclusively as an Administrator In Training and has not simultaneously held any other position in this facility. During the course of this training, the trainee was exposed to all aspects of nursing home management and the operation of the named facility, including the following: admittance procedures, patient care policies, utilization review processes, in-service training procedures, social services, medical records, housekeeping and sanitation, dietary and kitchen operations, medical department and applicable rehabilitation procedures, laundry services, purchasing procedures, personnel department procedures and policies, management functions including budgeting, billing, accounts receivable and payable, and departmental scheduling, etc.

I have been licensed in good standing for a least five years.

Under the penalty of perjury, this affidavit has been signed after the completion date of the AIT.

Signature of Administrator Date

Notary Public Notary Expiration Date

Effective Date of This Document Seal